PRINTED: 10/19/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED 06/19/2012			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 155793		A. BUILDING 00					
		133793	B. WIN			00/19/	2012		
NAME OF P	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE				
HAMILTON TRACE OF FISHERS LLC				11851 CUMBERLAND RD FISHERS, IN 46037					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION		
TAG F0000	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG		DEFICIENCY)		DATE		
1 0000									
	This visit was for the Investigation of Complaint IN00109640.		F0000						
	Complaint IN00100640								
	Complaint IN00109640 - Unsubstantiated.								
	Onsubstantiated.								
	Survey date: June 19 2012								
	Facility number 01264								
	Provider number 155793								
	AIM number 201046710a								
	1 11111 11011110 01 20	10.10,100							
	Survey team:								
	Chuck Stevenson RN								
	Census bed type: SNF: 32 SNF/NF: 66 Total: 98								
	Census payor ty	pe:							
	Medicare: 31								
	Medicaid: 35								
	Other: 32								
	Total: 98								
	Sample: 3								
		es also reflect State accordance with 410 IAC							
	10.2.								

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/19/2012 FORM APPROVED OMB NO. 0938-0391

ATION NUMBER:	A. BUILDING B. WING			COMPLETED 06/19/2012		
;	STREET ADDRESS, CITY, STATE, ZIP CODE 11851 CUMBERLAND RD FISHERS, IN 46037					
OF DEFICIENCIES E PRECEDED BY FULL IFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION D BE DPRIATE	(X5) COMPLETION DATE		
		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE DPRIATE			
	ATION NUMBER: OF DEFICIENCIES E PRECEDED BY FULL IFYING INFORMATION)	A. BUILDING B. WING STREET A 11851 C FISHEF OF DEFICIENCIES E PRECEDED BY FULL FYING INFORMATION) A. BUILDING B. WING STREET A 11851 C FISHEF A. BUILDING B. WING PREFIX TAG	A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 11851 CUMBERLAND RD FISHERS, IN 46037 OF DEFICIENCIES E PRECEDED BY FULL FYING INFORMATION) A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE (FISHERS, IN 46037) PROVIDER'S PLAN OF CORRECT (FACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 11851 CUMBERLAND RD FISHERS, IN 46037 OF DEFICIENCIES E PRECEDED BY FULL FYING INFORMATION) A. BUILDING DO COMPI 06/19		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YL2D11

Facility ID: 012644

If continuation sheet

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